SYNERGY
What It Takes!
SWS National Newsletter
Volume 4 Number 2

"IT'S THE SOCIAL WORKERS!"

By Ken Shay, MD
Director Geriatrics and Extended Care, VISN 11

I hadn't even moved out of my previous position in late summer of the last century when I received The Directive. "Please come up with a network-wide standard practice of admission and discharge to long-term care, with an eye toward minimizing the use of contracts. Oh, and you have until March." I hadn't even turned in my dental floss!

With the indefatigable assistance of the Service Line Board, and especially my Assistant Director, Sherry, a network-wide review of policies began. Several weeks, gallons of strong coffee, and countless reams of xerox paper later, we found the common thread - the key - the hidden cipher - the missing link. "It's the social workers!"

Every member of the multidisciplinary team plays a valuable role in the assessment and management of the long-term care patient. No team would be complete without its nurses, physicians, therapists, and dieticians. But what shouted loudest to me from all the policies, directives, information letters, and program manuals was that in our system, it is the social workers who most predictably and universally act as the gatekeepers when it comes to entry into long-term care, particularly contracted care. Therefore, to learn about what is going on, and to find out what needs to be fixed, and to figure out how to fix it: "It's the social workers, stupid!" ♦

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Congratulations

Jill Manski, MSW, LISW has been selected as the new Director of Social Work in Headquarters. Ms. Manski had been the Chief, Social Work Service, New Mexico VA Health Care System, Albuquerque, NM, prior to her selection to this Headquarters position. Ms. Manski started her new assignment in August.

Psychological Reports, 2000, 86, 21-24.

PROGRAM REVIEW OF COMMUNITY RESIDENTIAL CARE[1,2]

By Annie R. Pope, MSW
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Summary - This article provides an overview of the Department of Veterans Affairs (VA) Community Residential Care Program and summarizes key literature about programs developed in the United States. Descriptive data for 1995 and 1996 are provided to assist program planners in comparing and contrasting client characteristics and services. The authors conclude that, in addition to being cost effective, the Residential Care Program strengthens relationships between the health care facility and the community it serves.

The emphasis in health care for the new millennium is on cost effectiveness as dictated by the implementation of managed care, i.e., predetermined costs for services rendered. As emphasis in care shifts from inpatient to outpatient status, the roles of allied health care workers, such as social workers and psychologists, become pivotal in developing and utilizing community resources.

One such resource, the Community Residential Care Program, has been developed and maintained for decades. Adult foster care was the forerunner of the modern Residential Care Program, originating in the late 1930s out of VA Medical Center, Tuskegee, AL. The basic concept of the Residential Care Program is to provide a substitute family for clients in an environment where medical and psychological needs can be met. Also, support is provided to the sponsors in whose homes the clients are placed. Case management has become the modal service delivery model for such outpatient psychiatric programs.

Studies of residential care homes have shown association between the care (frequency and duration) and social climates within facilities. Timkos and Moos (1990) found evidence to suggest that interpersonal support and self-direction were associated with an enhanced quality of care. In a follow-up study, Timkos and Moos (1991) recommended interventions for differing social climate types to increase independence. Davis and Gerard (1993) found significant associations between satisfaction with residential care and a variety of characteristics of the setting such as security of belongings, activities available, and employment opportunities. All of the studies concur that the essential factor to quality care is the sponsor or principal caregiver.

In 1982 the average cost of residential care, based on a nationwide survey, was $484 per month compared to an average cost of nursing home care of $1,500 per month (McCoin, 1985). As of 1995, while the cost of patients' residential care had risen to $725 per month, nursing home costs had risen to $5,658 per month. In addition, it is important to note that the residential cost, unlike that of nursing home care, is defrayed by the patients' personal funds.

METHOD

Clinical and demographic data were obtained for 1995 and 1996 from the Veterans Health Administration (VHA) database for veterans who were placed in residential care. Information included resources used, prior living arrangements, diagnostic categories, care (frequency and duration), type of psychosocial problem, and special population characteristics.

Programmatic data included directive services, i.e., services made available or provided to patients, VA-sponsored resources needed, and resources utilized by patients. Finally, programmatic psychosocial outcomes were obtained, including whether planned results were attained, and barriers to attaining such results. Data reflect program information, and therefore figures represent cases closed for the respective years rather than unique cases.

Thus, if a person entered the program in 1995 and dropped out, but later reentered, that person is counted twice with data reflecting the characteristics of the person

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at the time the case was closed. Thus, the actual program effort is reflected rather than a summary depiction of the program participants. The number of such cases with nonunique identifiers is 16% for the study period.

RESULTS

Records for 8,340 cases were obtained for 1995, and 5,654 cases for 1996. Patients' characteristics are summarized in Table 1. VA hospitals were most often listed as the patients' prior living arrangements, followed by other arrangements, and patients' own homes. A decline of 8.2% was noted from 1995 to 1996 in prior living arrangements being at VA hospitals. A slight decline of 5.8% in patients with psychological disorders from 1995 to 1996 was also noted.

TABLE 1
Diagnostic Categories of Military Veterans Placed In Residential Care and Level of Care: Percent

Diagnosis	1995*	1996†	Level of Care	1995*	1996†
Medical	11.7	6.0	Light	28.5	28.1
Psychosis	79.6	73.8	Moderate	56.9	54.5
Brain Syndrome	5.6	6.1	Heavy	14.5	17.2
Substance Abuse	2.5	2.8			

**N* = 8,340. †*N* = 5,654.

Care (cf. Table 1), including frequency and duration, was moderate in slightly over 50% of patients in both years, followed by light levels of care (28.5%) and heavy levels of care (14.5%). Special population data indicated only small percentages (i.e., less than 1%) in spinal cord injury and Autoimmune Deficiency Syndrome (AIDS) cases. The homeless population increased slightly from 1.7% in 1995 to 3.5% in 1996.

For each of 38 possible psychosocial problems recorded for patients, there were minimal changes between years; 9,771 problems were recorded for 1995 (for 8,340 cases), and 7,080 problems (for 5,654 cases) for 1996. The most common psychosocial problems that required VA services were (a) patient's and family's adjustment to placement, (b) psychosis, and (c) patient's or family's adjustment to chronic illness.

TABLE 2
Direct Services to Military Veterans Placed in Residential Care and Psychosocial Problem Outcomes: Percent

Service	1995*	1996†	Outcome	1995¥	1996[a]
Assessment	11.1	13.6	Planned Results Attained	58.0	61.0
Treatment	16.0	14.6	Partially Attained	31.0	25.8
Financial	5.6	6.3	Not Attained	10.9	13.2
Care Continuity	14.4	13.6			
Case Management	26.6	27.1			
Team Conference	5.6	5.0			
Home Visit	16.3	15.4			
Other	4.4	4.5			

**N* = 8,340 cases, 21,980 services. †*N* = 5,654 cases, 14,118 services.
¥1995, *N* = 8,340. [a]1996, *N* = 5,654.

In response to the above psychosocial problems, VA direct services were provided patients for one or more of several categories. Since some patients received multiple services, the percentages listed in Table 2 represent the percentage of total services provided for each category, rather than the percentage of cases; *21,980* services were provided in *1995* and *14,118 in 1996.* Table 2 also lists outcomes related to the psychosocial problems reported in Table 2. Of the potential problem outcomes, planned results were attained in over *56%* of cases for both *1995* and *1996.* Partial attainment of planned results was obtained in 40% of the *1995* cases and in *25.8%* of *1996* cases. Results were not attained in *10.9%* for *1995* and 13.2% for 1996. The most common reasons for not attaining results or for attaining only partial results were barriers associated with the patient and family rather than with the VA Medical Center or community.

CONCLUSION

The Residential Care Program within the VA is unique in that most of the cost of care is assumed by the clients themselves. The cost to the government for salaries of the multidisciplinary treatment is minuscule compared to alternative resources such as nursing homes or inpatient psychiatric care. In addition to being cost effective, residential care strengthens relationships between the health care facility and the community it serves. Residential care is an appropriate service in the managed care model of health care delivery and exemplifies the objectives of primary care.

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Management of Overweight Elderly Patients: A Pilot Project*

By Jaime Alvelo, DSW
VAMC San Juan, PR

It is estimated that over 97 million adults and elderly, in the United States, are overweight or obese (Jensen & Rogers, 1998)**. It is also estimated that the cost of treating diseases, associated with this problem, is as high as $99 billion; and, it is the second largest leading cause of preventable death.

Health risks associated with problems of overweight are: insulin resistance, non-insulin-dependent diabetes mellitus, hypertension, cholesterol and other body fat problems, cardiovascular disease, gallstones, inflammation of the gall bladder, respiratory dysfunction, and certain forms of cancer. The greater the overweight problem, the greater the chances are of developing these health problems and of a greater death rate at an earlier age.

Obesity is defined as a condition in which there is an excess of body fat, usually associated with being overweight, when compared to population norms. This norm is subdivided and compared to body weight related to age, gender, height, and frame size. In males, more than 20% of fat mass is considered to be normal; and in females more than 28% of fat mass is considered to be normal. Body mass index (BMI) range fluctuates. However, as a rule of thumb, BMI between 20-25 is normal; and, between 25-30 is considered mild obesity. By the same token, BMI between 30-40 is considered moderate obesity. Anything above 40 is considered severe morbid obesity.

Increased physical activity is the key component of both long-term and short-term weight loss maintenance programs. Increased physical activity is unlikely to result in short-term weight loss unless used in conjunction with proper dietary adjustments. Several prospective studies have suggested that weekly increases in physical activity and the use of 1,500 to 2,000 kilocalorie energy per day are most effective in long-term weight loss. A variety of aerobic activities are suitable for persons trying to lose weight; but, most people will benefit from brisk walking as a cornerstone to their increased physical activity.

As part of its commitment to Primary Prevention, VAMC San Juan conducted a pilot study of a weight management program for veterans between the ages of 60 and 75. The objective of the project was to improve the health profile (weight, blood pressure, lipid profile, blood sugar, anxiety, and self-esteem) of elderly overweight veterans through an interdisciplinary weight management program. The study plan consisted of recruiting a sample of elderly veterans and through an intensive 10-week program (providing dietetic, psychosocial, and exercise interventions) alleviate the health problems associated with being overweight.

Method

The design of the study was a pre- and post-experimental design. Subjects consisted of 18 veterans from Primary Care and Geriatric Evaluation Medical (GEM) clinics at VAMC San Juan. The lack of sufficient subjects precluded the use of a control group. Inclusion criteria were: veterans who had a BMI of 27 or greater, and were between the ages of 60 to 75. Exclusion criteria were: veterans chronically bedridden; HIV positive or AIDs; cancer; active tuberculosis; hemodialysis; males over 75 years old; major surgeries; receiving intensive care; and cardiac patients.

Data were collected using a standard form indicating the subject's weight, lipid profile, blood glucose levels, and blood pressure at weeks 1 and 10 of the study period. The form also included demographic information on the subjects such as age, medical diagnosis, BMI, martial status, and height. In addition, standard scales of self-esteem and stress levels (anxiety sub-scale of the Psychiatric Symptom and Dysfunction Scales [PSDS]) were collected at both times. Interventions consisted of 10 two-hour sessions with: one hour focal therapy sessions by social workers aimed at dealing with the psychosocial components of obesity; half-hour education and weight monitoring sessions with the dietician; and, a half-hour exercise program with home self-monitoring by the recreational therapist. All subjects were assured voluntary participation and confidentiality. Data collection forms had no patient specific identifiers (SSN or names). Statistical analysis was done using SPSS. Analysis consisted of obtaining descriptive information on the veterans, and testing for differences in means using the t-test for dependent samples.

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DEPARTMENT OF VETERANS AFFAIRS
SOCIAL WORK SERVICE

In cooperation with the
National Social Work Education Committee,
Association of Social Work Managers
And
VA Social Work Leadership Council
Co-sponsored by Health Care Finance Administration (HCFA)

Presented

SOCIAL WORK 2000
CONTINUITY AND CHANGE FOR COMMUNITY INTEGRATION

September 11 -15, 2000

Las Vegas, NV - New Frontier Hotel

Purpose: Provided VA facilities assistance for integration of services from the medical center into the community through social work services.

Expected Outcome: Assisted in cost saving measurements, data evaluations, as well as outcome measurements for health care.

Target Audience: Members of the Association of Social Work Managers, social workers in leadership roles, designated social work leadership contacts at medical centers, and Nutrition and Food Service Advisory Council.

Objectives: At the conclusion of this conference, participants were:

1. Understand the future of the VA as conceptualized by top leadership;
2. Describe the collaboration between HCFA and Veterans Health Administration (VHA);
3. Understand the future role of social work in the VA and in health care in general;
4. Develop meaningful responses to needs in the areas of professional standards, innovative thinking, resource planning, and managed care;
5. Understand the future of geriatrics and mental health care in VHA;
6. Discuss the future roles of social work from the perspective of the National Association of Social Workers and the Society for Social Work Leaders in Health Care;
7. Discuss innovative program ideas presented by VA colleagues; and,
8. Identify partnership opportunities with community agencies.

Evaluation: Participants completed an overall program evaluation at the conclusion of the conference.

Certificate of Attendance: A certificate of attendance was awarded to VA employees. In order to receive this certificate of attendance, participants had to attend 100% of the Program and complete an evaluation form. CEU's were provided.

Report of Training: It is the program participants' responsibility to assure that the training is reported to their respective TEMPO Coordinator in order for it to count toward the 40 hours of required training. ♦

*Management of Overweight Elderly Patients: A Pilot Project**

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Results

The average age of the veterans was 68. Results indicated that after 10 weeks of participating in an interdisciplinary weight management program, the 16 veterans who completed the study had significant changes from initial to final scores in weight (P>.001; 211 vs. 201). Triglyceride levels (P=.005; 135 vs. 110), self esteem (P=.004; 31.3 vs. 34.8), and anxiety (P=.017; 12.44 vs. 9.6). The average weight loss was 9.13 (range was +1 to -17) pounds with all but one losing weight (94%). No significant differences were found in blood pressure or glucose levels. This pilot study suggests that an intensive weight management program is effective in achieving weight loss and improving other bio-psychosocial parameters of health. Further studies are suggested with larger samples and more rigorous research.

* The pilot project was running under the auspices of Primary Care Educational (PRIME) Program coordinated by Melba Feliciano, MD, ACOS for Extended Care and Geriatrics; and, the Principal Investigator was Jaime Alvelo, DSW, Social Work Researcher. The treatment team that developed the pilot project was composed of Margarita Caban, Social Worker; Douglas Henao, Registered Dietician; Delia Kraemer, Social Worker; Jorge Salgado, Recreational Therapist; and, Ubaldo Santiago, MD. College students from Sacred Heart University provided additional support to the recreational therapy component.

**Jensen, G.L. & Rogers, J. (1998). Obesity in older persons. Journal of the American Dietetic Association, 98(11), 1308-1311. ♦

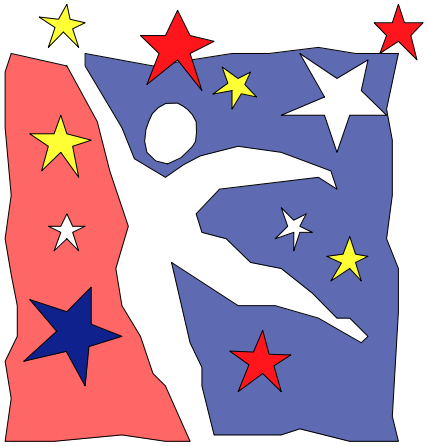
Specialized Sexual Trauma Treatment Program

By Iris Chaffin, MSW
Women's Sexual Trauma Treatment Program
VAMC Bay Pines, FL

The Women's Program at VAMC Bay Pines, FL recently received funding, under VA Headquarters' Innovative Program Initiative, to develop a very unique program for the treatment of sexual trauma. The program will include both a day treatment program and a women's residence in the community for those patients who need housing during their treatment. The residence for women veterans is being supported by the cooperative efforts of the Women's Program, community agencies, and veterans service organizations. It is hoped that this type of program will be replicated across the country as an effective, cost-efficient, and innovative modality for the provision of treatment that involves partnership with community agencies.

The program is designed to provide treatment for individuals with a history of sexual trauma, and resulting psychological symptoms, that are unlikely to be resolved by outpatient therapies alone. Most models of trauma treatment include an "exposure" component in which the patient directly reviews and confronts the details of the trauma. For many patients, this is the most difficult part of the treatment process because of the associated feelings of vulnerability and the fear of becoming overwhelmed. The Day Treatment Program is designed to address this specific aspect of treatment while also providing other therapies to facilitate the ongoing outpatient treatment of the patient. The Day Treatment Program is a 28-day full-time program that will include trauma work, skills training, recreation, health education, goal setting, and aftercare planning.

Referrals to the Day Treatment Program are accepted from mental health professionals from any VA, Department of Defense (DoD), Vet Center, or participating community agency; and, require detailed referral information and an agreement to provide or arrange appropriate aftercare services. The Day Treatment Program is expected to open in August 2000. In addition to the Day Treatment Program, outpatient therapy, consultative services, and educational and research activities are important aspects of the Sexual Trauma Treatment Center at VAMC Bay Pines. For more information, contact Carol O'Brien, PhD, Program Director at 727.398.6661 extensions 4312 or 7579, or Iris Chaffin, MSW, Community Liaison, at extension 7055. ♦



"It's the Social Workers!"

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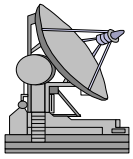
So, with the help of Moses Deese at VA Northern Indiana Health Care System, a meeting with key social work staff from all seven sites was hastily convened at Fort Wayne on February 15th. All stations were represented; and, all representatives freely contributed thoughts, concerns, ideas, and opinions. I came away with a much better understanding of contracting, of community care, of Medicaid, and of our Service Line than I would have thought possible in such a short time. In addition, the other participants learned about each other, other stations in the network, which problems they shared, what were some solutions, and how some were better than others.

Meetings like this build the Service Line by bringing together those who are involved, by getting them to identify the problems, by working with them to suggest, and then to evaluate solutions. In the process they form a new work unit, even as they bring back new ideas to their home stations from what they have taken from and given to the meeting. I really look forward to other situations that may arise that will call for working with other groups in the Network. Can you blame me?

I had a terrific day learning from and working with Moses, Bill, Peggy, John, Sandy, Dave, Larry, and Geoff. "It's the social workers!" ♦

Virtual Library of Materials for Social Work Staff Development

By Nancy Campbell, MSW
Chief, Social Work Service
VAMC Cincinnati, OH



Are you looking for fresh ideas for your social work staff development programs? Does your staff need help in getting enough continuing education credits to maintain their licenses and upgrade their competencies? How are you doing in meeting the new VA requirement of 40 hours of training per year?

With money for education drying up in some places, perhaps it has become more difficult to bring in good speakers or to send staff members to worthwhile programs offered elsewhere. Such circumstances challenge us to be creative in coming up with ways to pool our resources and to share good learning opportunities we have heard about, or experienced, at our facilities and in our communities. How might this be accomplished? By creating our own circulating virtual library!

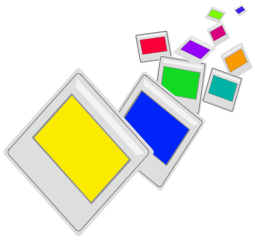
What kinds of resources could this library stock? Here are some possibilities:

- Because of our affiliations with schools of social work across the country, and with groups such as National Association of Social Workers and Society of Social Worker Administrators in Health Care, we have access to national renowned speakers. Perhaps they would be willing to have their presentation taped for viewing by others if they speak at your facility or in your community.
- Many presentations are now being done using Power Point software, and can be easily shared with others as attachments to E-mail messages.
- There are many good computer-based training modules available on such topics as patient rights, advance directives, and dealing with patient abuse. Some of them have pre- and post-tests, which are excellent means of determining whether or not someone possesses competence in that area and the effectiveness of the learning experience. This can come in handy during a Joint Commission on Accreditation of Healthcare Organizations review when questions regarding competency and training are asked.
- You, or someone on your staff may have read an excellent book that they might be willing to share with the rest of us, by either providing the reference, or a short review that can be sent out as an OUTLOOK attachment, or posted on our web site.
- Satellite conferences are offered by many health care organizations. Perhaps there are ways for the rest of us to hook into some of them.
- Pharmaceutical companies often sponsor well-known speakers with nationally recognized expertise on a variety of topics, and are sometimes willing to subsidize their travel expenses.

How would we be able to let each other know of these resources and how to access them?

I am a member of the Social Work Education Committee, and have agreed to be the "virtual librarian" and serve as the repository for these resources. A list of all these resources and contact persons will be maintained in Cincinnati, and updated regularly as new resources become known. This document will be sent out to the entire social work managers mail group, and perhaps could also be posted on our VA Social Work Web Site. Recipients could then decide how to best make use of this information at their sites.

As this is much a work in progress, the Social Work Education Committee would be very interested in your thoughts/suggestions/reactions to this idea. Members are Nancy Campbell at Cincinnati, Jim Morrison at Huntington, Mike Juvenal at Iowa City, Jo Ann Bright at Dallas, Larry Peterson at Durham, George Templeton at St. Louis, Stanley Remer at Kansas City, Terry Harbert at Topeka, Rita Range at Memphis, and Monica Green at Jackson. ♦



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[1]The authors extend thanks to the VA Office of Academic Affairs for providing funds for them to meet, and to the VA Austin Automation Center for providing data for analysis. We especially thank Don Moses, Acting Director of Social Work Service, for his encouragement and leadership. In addition, the effort received the continuing support of the Research and Program Evaluation committee of VA Social Work Service, in particular, Dr. Jaime Alvelo; Dr. Joseph Englehardt; and Dr. Rick Connis, who completed the statistical analysis of the data. This project was funded in part by VA Health Services Research Program, IIR 94-125.

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Accepted January 3, 2000♦

Next Edition:

We welcome articles from anyone who wishes to address health care issues within the Department of Veterans Affairs. While social workers are our primary target group, contributors can be from any discipline. SYNERGY is an excellent tool for communicating information and ideas with hundreds of your peers. Articles for the next edition of SYNERGY should be sent to Rocco Bagala via MS Exchange or Fax'd to 206.764.2514 by October 31, 2000.